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Legal Alert

August 7, 2019

Washington's Balance Billing Protection Act: Is Your ASC Prepared?

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On May 21, 2019, Governor Jay Inslee signed into law House Bill 1065, the Balance Billing Protection Act (the "Act"). The Act goes into effect January 1, 2020 and will have broad implications across the state for health care providers and facilities, including ambulatory surgical facilities ("ASF"). In general, the new law prohibits balance billing by health care providers and facilities in certain instances and mandates additional measures designed to protect consumers from unexpected medical bills.

The Legislative Intent behind the Balance Billing Protection Act

The practice of "balance billing" is described by the Act as sending "a bill . . . to an enrollee by an out-of-network provider or facility for health care services provided to the enrollee after the provider's or facility's billed amount is not fully reimbursed by [health insurance] carrier, exclusive of permitted cost-sharing." The Legislature enacted the Balance Billing Protection Act to address concerns related to consumers receiving balance bills for services provided at out-of-network facilities or provided by out-of-network health care providers at in-network facilities. In an effort to prevent consumers from being placed in the middle of contractual disputes between health care providers and facilities and health insurance carriers, the Act seeks to share responsibility among providers, facilities and carriers to ensure consumers have transparent information on network providers and benefit coverage.

As a result of these concerns, the Legislative intent behind the Act is threefold: 1) to ban balance billing of consumers enrolled in fully insured, regulated insurance plans and plans offered to public employees; 2) to remove consumers from balance billing disputes and require that out-of-network providers and facilities and health insurance carriers negotiate out-of-network payments in good faith; and 3) to provide an environment that encourages self-funded groups to negotiate out-of-network payments in good faith with providers and facilities in return for balance billing protections.

Prohibitions on Balance Billing

The prohibitions on balance billing set forth in the Act only apply to out-of-network providers or facilities for 1) emergency services provided to an enrollee, or 2) nonemergency health care services provided by an out-of-network provider to an enrollee at an in-network hospital or an in-network ASF if the services involve surgical or ancillary services. The Act defines "surgical or ancillary services" as "surgery, anesthesiology, pathology, radiology, laboratory, or hospitalist services". Under these circumstances, providers and facilities are prohibited from billing the consumer for any difference in the in-network rate and the out-of-network payments received from the insurer.

Notice to Consumers Required under the Act

The Act sets forth certain mandated notifications by facilities, including ASFs, to consumers that facilitate information-sharing and transparency. First, an ASF is required to post on its website the health plan provider networks with which the ASF is an in-network provider. Second, the ASF is required to post on its website a standard template notification developed by the Office of the Insurance Commissioner ("OIC") informing consumers of their rights under the Act. The notification is required to describe the circumstances in which consumers may be balance billed and also provide contact information for the OIC for consumers to report violations of the Act. If an ASF does not maintain a website, this information must be provided to consumers upon request.

Notice to Carriers Required under the Act

ASFs must provide health insurance carriers with a list of the non-employed providers or provider groups with which the ASFs have contracts to provide surgical or ancillary services at the facility no less than 30 days prior to executing a contract with a carrier. Similarly, ASFs must notify the carrier within 30 days of any provider or provider group removed from or added to the list of non-employed providers.

Good Faith Negotiations with Carriers

The Act has many components that carriers must follow that also provide notice and information to consumers in regard to in-network and out-of-network concerns. Some of these mandates involve carrier relationships with health care providers and facilities. The Act specifies that health care providers and facilities are required to negotiate and engage cooperatively in determining appropriate out-of-network rates. Out-of-network rates must be a commercially reasonable amount based on payments for the same or similar services provided in the geographic area. Health insurance carriers must offer to pay a provider or facility a commercially reasonable amount. Amounts paid for out-of-network health care services must be paid directly to the provider or facility – not to the consumer. A provider or facility can dispute the offered amount within 30 days after receipt of payment or payment notification from a carrier, at which point the parties must negotiate in good faith. If the dispute cannot be resolved within 30 calendar days, the commercially reasonable amount of the services provided is subject to arbitration.

Consumer Obligations and In-Network Cost-Sharing Ceilings

The Act also places certain obligations on the consumer, who is still required to pay the in-network cost sharing amount as specified in the applicable insurance plan for any out-of-network services received. The out-of-network provider or facility must ensure, however, that the consumer bares no greater cost than the amount required to be paid for in-network services. If a consumer pays an out-of-network provider or facility an amount that exceeds the in-network cost-sharing amount, the consumer must be refunded the excess amount paid. If this amount is not refunded within 30 business days, the unrefunded amount will be subject to 12 percent interest beginning the first calendar day after the 30 business days.

Violations and Penalties

Violations of the Act will be considered unprofessional conduct for anyone with a professional license. In addition, the OIC may investigate any report that an ASF has engaged in a pattern of behavior that violates the prohibitions on balance billing set forth in the Act. Fines in the amount of $1,000 per violation can be levied against the health care provider or ASF in addition to any formal or informal disciplinary actions taken by the Department of Health.

Practical Takeaways

ASFs must be compliant with the Act by January 1, 2020.

- ASFs should review their billing practices to ensure balance billing is not occurring in violation of the provisions of the Act. Specifically, billing practices involving out-of-network providers should be carefully reviewed to determine whether costs associated with the provider's out-of-network status with a health insurance carrier are not being passed on to patients.

- ASFs should ensure that their websites list their in-network carrier relationships and be prepared to include the template language to be developed by the OIC.

- ASFs should have prepared a list of non-employed providers or provider groups with which the ASFs have contracts to provide surgical or ancillary services to provide to carriers and establish a process to update the list within 30 days of any change.

For more information, please contact Emily R. Studebaker, Esq. at (425) 279-9929 or estudebaker@studebakernault.com.